U.S. Representative Harley O. Staggers, Sr., of West Virginia said, ''I rise in support of the conference report which will stimulate development of health maintenance organizations. . . . I think that this new system will be successful and give us exciting and constructive alternatives to our existing programs of delivering better health services to Americans.''

In the Senate, Kennedy, author of the HMO Act, also encouraged its passage: ''I have strongly advocated passage of legislation to assist the development of health maintenance organizations as a viable and competitive alternative to fee-for-service practice. . . . This bill represents the first initiative by the Federal Government which attempts to come to grips directly with the problems of fragmentation and disorganization in the health care industry. . . . I believe that the HMO is the best idea put forth so far for containing costs and improving the organization and the delivery of health-care services.'' In a roll call vote, only Senator Herman Talmadge voted against the bill.

On December 29, 1973, President Nixon signed the HMO Act of 1973 into law.

As patients have since discovered, the HMO—staffed by physicians employed by and beholden to corporations—was not much of a Christmas present or an insurance product. It promises coverage but often denies access. The HMO, like other prepaid MCOs, requires enrollees to pay in advance for a long list of routine and major medical benefits, whether the health-care services are needed, wanted, or ever used. The HMOs are then allowed to manage care—without access to dollars and service—through definitions of medical necessity, restrictive drug formularies, and HMO-approved clinical guidelines. As a result, HMOs can keep millions of dollars from premium-paying patients.

HMO BARRIERS ELIMINATED

Congress's plan to save its members' political skins and national agendas relied on employer-sponsored coverage and taxpayer subsidies to HMOs. The planners' long-range goal was to place Medicare and Medicaid recipients into managed care where HMO managers, instead of Congress, could ration care and the government's financial liability could be limited through capitation (a fixed payment per enrollee per month regardless of the expense incurred by the HMO).

To accomplish this goal, public officials had to ensure that HMOs developed the size and stability necessary to take on the financial risks of capitated government health-care programs. This required that HMOs capture a significant portion of the private insurance market. Once Medicare and Medicaid recipients began to enroll in HMOs, the organizations would have the flexibility to pool their resources, redistribute private premium dollars, and ration care across their patient populations.

Using the HMO Act of 1973, Congress eliminated three major barriers to HMO growth, as clarified by U.S. Representative Claude Pepper of Florida: ''First, HMO's are expensive to start; second, restrictive State laws often make the operation of HMO's illegal; and, third, HMO's cannot compete effectively in employer health benefit plans with existing private insurance programs. The third factor occurs because HMO premiums are often greater than those for an insurance plan.''

To bring the privately insured into HMOs, Congress forced employers with 25 or more employees to offer HMOs as an option—a law that remained in effect until 1995. Congress then provided a total of $373 million in federal subsidies to fund planning and startup expenses, and to lower the cost of HMO premiums. This allowed HMOs to undercut the premium prices of their insurance competitors and gain significant market share.

In addition, the federal law pre-empted state laws, that prohibited physicians from receiving payments for not providing care. In other words, payments to physicians by HMOs for certain behavior (fewer admissions to hospitals, rationing care, prescribing cheaper medicines) were now legal.

The combined strategy of subsidies, federal power, and new legal requirements worked like a charm. Employees searching for the lowest priced comprehensive insurance policy flowed into HMOs, bringing their dollars with them. According to the Health Resources Services Administration (HRSA), the percentage of working Americans with private insurance enrolled in managed care rose from 29 percent in 1988 to over 50 percent in 1997. In 1999, 181.4 million people were enrolled in managed-care plans.

Once HMOs were filled with the privately insured, Congress moved to add the publicly subsidized. Medicaid Section 1115 waivers allowed states to herd Medicaid recipients into HMOs, and Medicare+Choice was offered to the elderly. By June 1998, over 53 percent of Medicaid recipients were enrolled in managed-care plans, according to HRSA. In addition, about 15 percent of the 39 million Medicare recipients were in HMOs in 2000.

HMOS SERVE PUBLIC-HEALTH AGENDA

Despite the public outcry against HMOs, federal support for managed care has not waned. In August 1998, HRSA announced the creation of a Center for Managed Care to provide ''leadership, coordination, and advancement of managed care systems . . . [and to] develop working relationships with the private managed care industry to assure mutual areas of cooperation.''

The move to managed care has been strongly supported by public-health officials who anticipate that public-private partnerships will provide funding for public-health infrastructure and initiatives, along with access to the medical records of private patients. The fact that health care is now organized in large groups by companies that hold millions of patient records and control literally hundreds of millions of health-care dollars has allowed unprecedented relationships to form between governments and health plans.

For example, Minnesota's HMOs, MCOs, and nonprofit insurers are required by law to fund public-health initiatives approved by the Minnesota Department of Health, the state regulator for managed care plans. The Blue Cross-Blue Shield tobacco lawsuit, which brought billions of dollars into state and health-plan coffers, is just one example of the you-scratch-my-back-I'll-scratch-yours initiatives. Yet this hidden tax, which further limits funds available for medical care, remains virtually unknown to enrollees.

Federal officials, eager to keep HMOs in business, have even been willing to violate federal law. In August 1998, a federal court chided the U.S. Department of Health and Human Services for renewing HMO contracts that violate their own Medicare regulations.

THE RUSE OF PATIENT PROTECTION

Truth be told, HMOs allowed politicians to promise access to comprehensive health-care services without actually delivering them. Because treatment decisions could not be linked directly to Congress, HMOs provided the perfect cover for its plans to contain costs nationwide through health-care rationing. Now that citizens are angry with managed (rationed) care, the responsible parties in Congress, Senator Kennedy in particular, return with legislation ostensibly to protect patients from the HMOs they instituted.

At worst, such offers are an obfuscation designed to entrench federal control over health care through the HMOs. At best they are deceptive placation. Congress has no desire to eliminate managed care, and federal regulation of HMOs and other managed-care corporations will not protect patients from rationing. Even the U.S. Supreme Court acknowledged in its June 12, 2000, *Pegram* v. *Herdrich* decision that to survive financially as Congress intended, HMOs must give physicians incentives to ration treatment.

Real patient protection flows from patient control. Only when patients hold health-care dollars in their own hands will they experience the protection and power inherent in purchasing their own insurance policies, making cost-conscious health-care decisions, and inciting cost-reducing competition for the cash.

What could be so bad about that? A lot, it seems. Public officials worry privately that patients with power may not choose managed-care plans, eventually destabilizing the HMOs Congress is so dependent on for cost containment and national health-care initiatives. Witness congressional constraints on individually owned, tax-free medical savings accounts and the reluctance to break up employer-sponsored coverage by providing federal tax breaks to individuals. Unless citizens wise up to Congress's unabashed but unadvertised support for managed care, it appears unlikely that real patient power will rise readily to the top of its agenda.

RECOGNIZING MAULDIN-DORFMEIER CONSTRUCTION

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 27, 2001

Mr. RADANOVICH. Mr. Speaker, I rise today to recognize Mauldin-Dorfmeier Construction for receiving the prestigious Excellence in Construction Eagle Award. Mauldin-Dorfmeier is receiving the ''Best of the Best'' Award from the Golden Gate Chapter of Associated Builders and Contractors.

Mauldin-Dorfmeier Construction, Inc. (MDC) was established in 1983 by Patrick Mauldin and Alan Dorfmeier. Their general contractors activities are focused in central and northern California. MDC has its administrative offices and construction yard based in Fresno.

MDC has a staff of over 55 professionals, including experienced project managers, engineers, and over 150 skilled craftsmen ready to take on any construction task. Their current bonding capability is in excess of $100 million, with the ability to bond individual projects in excess of $50 million.

Mauldin-Dorfmeier has received many industry awards, including the coveted ''Constructor Award for Excellence in Client Service,'' awarded by the Associated General Contractors of California for the Bulldog Stadium Expansion.

Mr. Speaker, I rise to recognize Mauldin-Dorfmeier Construction, Inc. for receiving the Excellence in Construction Eagle Award. I urge my colleagues to join me in wishing Mauldin-Dorfmeier many more years of continued success.